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¹J. Biol. Chem., 76:2. ²Ibid., 66:451.

³Ibid., 80:15. ⁴Ibid., 76:251.

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ORIGINAL ARTICLES

PRESENT DAY INTERPRETATION OF BASAL METABOLISM*

By GUY W. WELLS, M.D.

Modern hospitals are spending larger amounts each year in the maintenance and development of their laboratories because diagnosis and treatment of disease involves to a great extent laboratory procedure. Research workers and physicians are working with tremendous energy to reveal through laboratory methods infallible signs which will aid them in their work. It is only natural that some of these methods will be retained while others will be discarded because of unwarranted assertions which trial and further study alone will reveal. We are not surprised, then, to hear the constant admonition to follow in doubtful cases clinical evidence in preference to other methods, to use our five senses instead of a laboratory.

In spite of failures and warnings, the laboratory type of research seems to be going on at a greater rate than ever before. There are encouraging signs, however. Research work is being supervised and controlled better than formally and physicians are becoming quietly more critical of it.

One procedure, the metabolism test, has gained increasing prominence with the profession particularly during the past five years. The literature on the subject is enormous. The Quarterly Cumulative Index Medicus, Vol. 5, list one hundred thirty six articles under the heading Metabolism. Many others involving the subject were listed under other titles. Nearly every hospital has a metabolism department and many doctors have a respiration apparatus or a calorimeter in their offices. Requests for basal metabolic rate determinations are now frequent. It seems well therefore to determine so far as possible if the information derived from the test is reliable and if the increasing use of it is justified.

The term, basal metabolic rate, means the chemical process that is going on in the body at a standard velocity. To bring about such a condition it is necessary to eliminate factors which influence the velocity of metabolism and these will be taken up later. One can easily understand the futility of comparing the metabolic rate of a patient who has been at complete rest for 14 hours with that of a man who has been riding a bicycle immediately before the test. The chemical changes in the latter must be considerable greater. We try, therefore, to reduce all patients to a standard minimum of activity consistent with other opposing factors before measuring the rate of the body's chemical process which takes place in the cells.

This standard minimum of activity, or basal condition, is brought about by putting a patient at rest and by permitting no food for 14 hours before the test is made. As DuBois has pointed out, even such precautions do not strictly produce a basal condition since the heart and respiratory muscles are still working but this effect may be disregarded for clinical purposes. Food also causes an appreciable rise in metabolism rate and therefore 14 hours are allowed to elapse so that the effect of absorption has been diminished as much as possible.

Whenever there occurs a transformation of energy, heat is liberated and the older type of instruments measured this heat produced. These instruments were necessarily large in order to hold an individual. They were also complicated and difficult to operate. The apparatus was insulated against heat loss to the outside and ingenious methods were devised for absorbing and measuring the heat by means of water running through pipes in the chamber. These instruments required much help and considerable technical skill but in the hands of well-trained men were exceedingly accurate and much of our knowledge of fundamentals of metabolism was obtained from their use. Experiments could be carried on for moderately long periods of time. The results obtained therefore approximated fairly closely the chemical reactions taking place within the body. They also paved the way for the introduction of other

*Read before the Providence Medical Association November 4th, 1929.

simpler machines such as we now use. Suffice it to say that the earlier types of calorimeters were never practicable for clinical purposes but did do a remarkable service in revealing information that could later be applied to disease.

Shortly it was found that heat could be estimated if the oxygen consumed and carbon dioxide eliminated by the body were known. This method is called "indirect calorimetry." The results are practically the same as those of the direct measurement of heat. When the amount of carbon dioxide given off is divided by the oxygen consumed the result is called the respiratory quotient. The heat value of oxygen for the various respiratory quotients is then multiplied by the amount of oxygen consumed to give the total amount of heat eliminated. With the introduction of indirect calorimetry the apparatus became simpler and more adaptable to clinical uses. Even then the technique was difficult and required careful attention to prevent errors.

Under basal conditions the respiratory quotient is 0.82 in the majority of cases. It does, however, in a few instances, vary considerably from that figure and if conditions are not basal the quotient will vary considerably in the same individual. Such changes will lead to a very appreciable error in the final reading.

If the respiratory quotient of 0.82 is assumed, the measurement of carbon dioxide is no longer necessary for we merely multiply the quantity of oxygen consumed by the heat value of oxygen at the quotient of 0.82. The apparatus now becomes exceedingly simple and can be used for clinical purposes if we make allowances for its limitations.

Although there are many kinds of respiration apparatuses they all involve the same principle. The patient's respiratory tract is in a closed circuit with the respiration apparatus. The subject inspires from a spirometer containing a measured amount of oxygen under a water seal. His exhalation returns to the spirometer through a jar containing soda lime which removes the carbon dioxide. Rubber gas mask valves prevent the inhalation and exhalation traveling in the wrong direction. By means of these a blower to insure a plentiful supply of oxygen is no longer necessary. After a given period of time, the oxygen consumed is determined by means of a scale attached to the side of the instrument. The changes in the

temperature of the spirometer are noted and the barometric pressure is taken. Corrections for these changes according to the laws of gases are made and thus the total oxygen consumption is determined.

The first sources of error to be guarded against are leaks in the circuit. A leak in the machine itself is easily detected if the operator will take the trouble to test his instrument for them at regular intervals. Unfortunately testing for leaks is frequently omitted after the first few times but it should form a definite part of every operator's routine, for nearly every instrument, sooner or later, will develop one. They are most frequently found in the rubber tubing which is prone to crack with long use. Other places which must be watched with vigilance during each test are the nose and mouth pieces. Patients do not always understand the object of them and in trying to make these parts more comfortable the subject will often loosen the nose-piece. Other subjects who have had repeated tests often sleep. The jaws may then relax sufficiently to cause a gradual and marked loss of oxygen. The resulting rate may be definitely abnormal. Even if the loss is slight, that error plus other minor ones may give incorrectly high readings which confuse the physician rather than aid him.

One other common fault is failure on the part of the operator to frequently test for carbon dioxide in the spirometer. The soda lime which removes carbon dioxide from the expired air lasts for variable lengths of time. There is only one way to determine its efficacy and that is to test for the presence of carbon dioxide in the oxygen that has returned to the spirometer from the patient. This test should be performed frequently at regular intervals regardless of the length of time the soda lime has been in use.

Thus far we have considered only technical mistakes which may be eradicated by carefulness and attention within the power of any ordinary individual. We now come to the more difficult problem of eliminating errors involving the patient.

The basal metabolic level is fairly constant for normal individuals of each species as is the blood count, weight, and other body functions. This fact makes it easy to determine the limits of normality for individuals and to compile tables for comparison. A large group of apparently normal

people of similar sex, age, height and weight will vary but slightly in their metabolism readings. Also the same individual usually maintains a moderately constant level.

The unit of comparison most commonly used is the heat produced per square meter of body surface. Although there have been frequent objections to the use of the surface area as a standard the majority of research workers seem to agree that it is the best practical method and is in general use today. Other factors which are also considered are sex and age. Delafield DuBois was able to work out a chart from which surface area may be determined readily. The heat produced per square meter of body surface per unit of time may then be compared with a normal person of the same sex and age. In general the female has a metabolic level 5 to 7% lower than the male except possibly in the earliest stages of life. Both sexes show the greatest metabolic rate at the age of $1\frac{1}{2}$ years. The rate then falls rather sharply for a time and then the decline is very gradual and slow. Puberty has always been an interesting field for speculation with the physician. Although the evidence is not sufficient, it appears to indicate that puberty has but very slight or no influence. Athletes will, in general, have a slightly higher rate than similar individuals who live a more sedentary life. There is also, possibly, a small increase during the winter months.

Magnus-Levy discovered the increased metabolism in exophthalmic goitre in 1893. He later found the rate diminished in myxedema. Since that time the thyroid has received perhaps more attention than any of the other ductless glands. With the introduction of respiratory apparatus the test has become our chief means of diagnosis. In fact, in the minds of most people the test and thyroid disease are almost synonymous. It is well, therefore, to see in what types of disease of the thyroid gland we may expect changes in the metabolic rate.

Diffuse colloid goitre is prevalent in certain regions of this country and is not uncommon in practice. The enlargement of the gland and symptoms dependent on enlargement are the patient's only complaint. As a rule there are no other signs. We would not then expect an increase in metabolism. In fact the metabolic rate is usually somewhat depressed. Plumer² gives the figures of a minus 8 to 18 and further believes that it does

not go below minus 20. In rates below the last figure he has not been able to get a history of goitre. The disease is most frequently seen in regions which lack iodine and can be cured by giving iodine at puberty. Probably diffuse colloid goitre can become exophthalmic goitre with the changes in the basal rate.

In exophthalmic goitre the test finds its greatest and most important use at the present time. Boothby³ defines it as "a constitutional disease apparently due to an excessive, probably an abnormal, secretion of an enlarged thyroid gland showing pathological diffuse parenchymatous hypertrophy and hyperplasia. It is characterized by an increased basal metabolic rate with resulting secondary manifestations, with peculiar nervous syndrome and usually exophthalmos, with a tendency to gastro-intestinal crisis of vomiting and diarrhea. The cause of the altered pathology and activity of the gland is not known." It will be seen from the definition that other signs may be present. Later we will note that an increased metabolism is present in other diseases and we must, therefore, take into account and evaluate these other signs rather than stake our entire diagnosis on one test. DuBois⁴ quotes Means as follows:

1. Patients with an outspoken clinical picture of hyperthyroidism invariably show increased metabolism, and those with definite clinical pictures of hypothyroidism invariably show decreased metabolism. Those with goitre but no signs or symptoms of abnormal thyroid function, for the most part, show normal metabolism.

2. Patients with atypical or incomplete clinical evidence of abnormal thyroid function may show normal or abnormal metabolism. The majority show normal metabolism.

3. By inference from the indirect evidence we believe that in these borderline cases, provided that in the first place a true basal rate is secured, and, provided that certain well-recognized causes for increased metabolism, such as fever, acromegaly, leukemia, and severe anemia are excluded, the findings of an increased basal metabolic rate is strong presumptive evidence of hyperthyroidism.

4. To that extent, then, the metabolism test is distinctly useful in differential diagnosis. Like all other laboratory tests it should only be interpreted

with due regard to all other clinical and laboratory findings and with due regard for its limitations.

It is in the border line cases that present ill-defined symptoms where the metabolic rate becomes most helpful. But here, as Means points out, the increased rate must be supported so far as possible by negative evidences of other diseases which raise the rate. This part of the diagnosis is too frequently omitted. Later an incorrect diagnosis is charged to the test.

Adenomatous goitres differ clinically from the colloid type in that the enlargement is nodular rather than diffuse. These are benign and as a rule do not show an increase either in symptoms or in the basal metabolic rate. If the enlargement in any way embarrasses the patient, that portion of the gland may be removed. A few of the adenomatous goitres, however, do increase the rate considerably. They are termed toxic adenomas. Exophthalmos is not common in them and diagnosis is usually delayed for sometime. In such cases the increased metabolism is of greater value than in those cases where other signs are prominent.

Malignancy of the thyroid gland may show a higher level than normal but malignancy outside of thyroid clinics is seldom suspected before death.

Although the determination of basal metabolism is used principally in those cases suspected of having an increased rate, I believe its greatest value will be found in patients with a lowered rate. For some unknown reason, this class of patients seems to have been greatly neglected by the profession. Perhaps it is because their signs except in marked cases are less acute and less recognizable. In well-developed myxedema the diagnosis is usually correctly made. These patients are relatively scarce. Borderline cases and those showing indefinite symptoms are a great deal more numerous than we formerly supposed, and, in most of such cases the metabolism test is the most reliable and often the only sign we have that is of any value. In hypothyroidism, just as in Graves disease, it is necessary to rule out other factors which cause low readings.

Since cretinism is seldom dependent on the determination of the metabolic rate for diagnosis we can merely state that it is lowered.

Other conditions influence the rate and in order to get the greatest benefit from the metabolism

test it is essential that we know what other diseases may show an abnormal reading.

Boothby has prepared an excellent table showing these diseases and their percentage of variation from normal. Chief among diseases with an elevated metabolism are the leukimias, only 6.3% falling within the normal limit. Polycythemia is another blood disease prone to show an abnormally high rate. In acromegaly the test is normal in about half the cases. In the remaining half a few will be low, the rest abnormally high. Paget's disease increases the metabolism in about one third the cases.

Lowered readings are found in hypopituitarism in slightly over half of the cases while a very few of them will have a moderately increased rate. In Addison's disease, there is lowering in about 20% of the number, but the effect of inanition and lack of epinephrin are confusing. 8% showed a rather surprising increase in rate that one would not expect. Dysphagia and epilepsy both have low rates in a large percentage of cases. Approximately one third of diabetic patients are low. It might be added, parenthetically, that the ordinary respiration apparatus such as we have in the clinic or in the office does not lend itself well to the accurate determination of rates in diabetic patients. Their respiratory quotient due to their failure to metabolize carbohydrates normally, is probably less than the average quotient 0.82 and the rate is likely, therefore, to be lower than that actually found.

In order to insure correct basal readings we must be certain that basal conditions are observed. Patients must have had no food for at least 14 hours before the test is performed, and they must be at rest. If the patient is to come to the office definite and explicit instructions about avoidance of undue exercise, as bathing, driving a car and unnecessary walking, must be given. A temperature above normal will increase the rate roughly in proportion to the fever. Complete rest and relaxation must precede the test or the effects of activity will also become apparent by an increase in rate. This last detail is the most difficult to secure and is too often slighted or omitted. No two patients are alike and different methods must be employed. Usually a brief, quiet explanation with a calm reassuring attitude is of most value.

Not all the conditions affecting a metabolism test have been discussed. Some important ones

have been omitted. Common sources of error have been taken up briefly because the metabolism test with a greatly simplified technique is rapidly becoming part of laboratory routine. It is only natural that inaccuracies will creep in and influence our interpretations, particularly when the test is performed by a technician. Once the profession understands the conditions which influence the reading the determination of the basal metabolism will have a much broader field of usefulness than it now offers.

¹Basal Metabolism in Health and Disease. Dubois,

²Oxford Med. 1923

³Oxford Med. 1923

⁴Basal Metabolism in Health and Disease. Dubois, page 245.

PSYCHOANALYSIS*

BY DR. SAMUEL STARR

PROVIDENCE, R. I.

Psychoanalysis is a recent and rather specialized method of treatment for functional diseases of the mind. It investigates the causes and the underlying mechanisms of various neurotic symptoms. The analytic procedure constitutes both the method of investigation and the treatment.

The evolution of psychoanalysis forms an interesting chapter in the history of medicine. In 1881, Freud and Breuer, both of Vienna, were treating a young woman suffering from hysteria. After the usual methods of treatment were found unsuccessful, it was noted that in explanation of her symptoms the patient offered only a part of the known medical antecedents. The other part of her history was concealed by an unconscious repression of painful experiences. By procedures which later developed into the refinements of the psychoanalytic method many hidden and absolutely forgotten experiences of her past with their attached emotions were brought to light; and it was shown that it was just these painful experiences which caused her hysterical symptoms. These memories were active emotional forces unconsciously repressed. Only when they were lived over again and brought to her conscious mind did the patient begin to improve.

*Read before the Jacobi Medical Club of Rhode Island, February 27, 1929.

From such a beginning, the science of psychoanalysis gradually has been developed. Psychoanalysis is both scientific and technical. From its data there has developed a new science having certain definite laws governing mental phenomena, just as definite as the laws of gravitation. This has been demonstrated theoretically and proved practically. The practical results obtained in the cure of severe cases of nervous illness completely harmonize with the underlying theories. Psychoanalysis has nothing to do with the data of the ordinary medical history as given by the patient, for the latter gives only a spontaneous recital of his difficulties or expresses only his conscious thoughts in reply to direct questions.

The analytic method was evolved partly through a dissatisfaction with hypnotism. Under hypnosis, the patient is made to recall and reproduce certain experiences. The theory deduced therefrom is that hysterical symptoms correspond to an abnormal use of undischarged sums of excitement. Hypnotism merely removes superficial material, but it does not penetrate deep enough into the unconscious mind. Furthermore, hypnotism puts something in the nature of suggestion into the patient's mind while psychoanalysis withdraws material from the unconscious. In other words, in the use of hypnotism the patient is dependent upon the hypnotist while in the use of psychoanalysis the patient is weaned away gradually from the analyst and is later able to go on in life as an independent personality.

Some critics claim that there enters into psychoanalysis an element of suggestion, namely, the patient's belief or faith that the treatment employed will cure him. Under no circumstances is this true. No explanations or suggestions are made if the treatment is carried out in the proper manner. The patient gradually sees things for himself and begins to understand his inner life.

Although great relief may be gained by secular confession, the confession of a repressed idea or a secret mental anguish does not cure; and if improvement takes place it is only temporary. This fact in itself invalidates the idea that the benefits of psychoanalysis are obtained by a process of mental catharsis or a free unburdening of the mind.

The best results have been obtained with the severe hysterias, the compulsion neuroses, the anxiety neuroses, stammering, neuresthenia, the

sexual neuroses (such as sadism, masochism, homo-sexuality), psychical impotence, and some mild cases of manic depressive insanity and paranoia. Kleptomania and certain cases of juvenile delinquency which are uncomplicated by mental defect or feeble-mindedness also may be helped materially. As a rule, persons over fifty years of age, severe cases of stammering, and advanced cases of paranoia and dementia precox are unsuitable for treatment.

Psychoanalysis is unfortunately complicated by a mystifying network of apparently confusing technical phraseology with which the general physician is rather unfamiliar. It is proper that some of the more common terms be placed in more frequent use by the medical fraternity. Knowledge of these terms is more apt to encourage the physician to avail himself of a really valuable therapeutic procedure.

"Determinism" is the technical phrase for designating the relation of mental cause and effect. The science of psychoanalysis presupposes a definite cause for every mental effect. Nervous symptoms are not chance and haphazard products. They are related to actual mental processes which are repressed in the patient's unconscious mind.

"Repression" refers to the attempt of the mind to find a refuge from mental conflicts. It is a defensive mechanism to neutralize or put out of action unwelcome and unpleasant thoughts. These thoughts are pushed back into the unconscious mind. And the efforts of these repressed thoughts to find an outlet produce the nervous illness. In fact, a great deal of the forgetting in normal individuals and in nervous illness is not due to any actual loss of memory, as is commonly supposed, but to an active repression. Repression underlies the forgetting of dreams, those losses of memory for limited periods of time termed amnesias, somnambulism, and also the condition known as double or multiple personality. The dream especially represents a symbolic expression of repressed thoughts.

"Resistance" is the force exerted to prevent unwelcome and unpleasant thoughts from becoming conscious. It arises in the unconscious mind of every neurotic patient during the battle between intellect and instinct. The process of resistance is particularly well seen in dreams. It is a sort of dream censor. It attempts to prevent all

the dream thoughts from coming out during an analysis, because so many of these thoughts deal with the most personal emotions of the individual.

A skeptical attitude on the part of the patient is a form of resistance. But it is no material obstacle to successful treatment. Psychoanalysis easily overcomes this resistance and thereby becomes a most important factor in the treatment of mental disease.

Resistance is an attempt to conceal the skeleton in the closet, the hidden complex, the secret anguish. It plays havoc with one's peace of mind; yet the attempt to open the door of this closet is often the cause of severe unconscious or even conscious opposition during analytic treatment. No psychoanalysis can be successful until these resistances are broken down. Above all other factors, it is probably this resistance which explains the long duration of nervous illnesses and the difficulty of successfully treating them. The patient resists getting well because this brings him in touch with reality which is very painful to him; whereas the neurosis into which he withdraws offers a refuge from reality. Thus the paradoxical statement of psychoanalysis becomes clear when it is stated that the patient gains something by his nervous illness and therefore dreads getting well.

"Transference" may be defined as a feeling of acknowledged sympathy emanating from the patient to the analyst, similar to that occurring in other lines of medical treatment when the patient shows confidence in his doctor. In neurotic patients this feeling is greatly exaggerated, for neurotics have a greater craving for sympathy than do those who are not nervously ill. Transference, therefore, is neither a specific result of or is it limited to psychoanalytic treatment.

Transference is the opposite of resistance. It is the substitution of a sympathetic feeling for a hostile one and is really derived from the patient's unconscious life. A successful transference is necessary for a successful psychoanalytic therapeutic result.

Transference may assist also in changing certain detrimental character traits in the treatment of those who are not nervously ill. The emotions are changed by the analytic process to a new and more useful form of energy. The patient learns to utilize this energy for a better purpose than that of struggling with his nervous illness.

Transference is not only one of the central problems of psychoanalysis, but it is most difficult and delicate to handle. One must be careful that the transference between patient and doctor does not become permanent. The dependence on the physician must be cut off so that the patient will become an independent personality when he is cured. Transference, therefore, is really a barometer of the patient's feelings toward the analyst and towards the neurosis. It usually manifests itself in the patient's dreams and in the rapidity with which the symptoms of the nervous illness subside and disappear.

The interpretation of dreams constitutes the most important instrument of psychoanalysis. Dreams throw light upon the real unconscious mechanism of the nervous sufferer. The neurosis has laid its foundation in the unconscious mind and it seeks expression in the dream. The latter, therefore, is really the royal road to the unconscious mind. The study of dreams, symptomatic actions, and sometimes the association of ideas offers a means of tracing each symptom backward into the patient's life history. The symptoms themselves may be found rooted deep in the earliest experiences of childhood.

A lot of misunderstanding and opposition to psychoanalysis has been due to the use of the term "sex." The term "sex," just as the term "wish," as used in psychoanalysis is a very broad one. It does not limit itself to the reproductive instinct. Neither does it mean that the chief object of psychoanalysis is to drag into the lime light a patient's sexual experiences. "Sexual" here is not the equivalent of sensual, but refers to the fundamental instinct which lies at the very heart of the emotional life, and which is called the "libido."

"Libido" means vital energy or instinct. It is not always sexual, since the instinct may be hunger or nutritional, beginning as infantile pleasure in nutrition and gradually shading over into the sexual. Hunger and sexuality are the two primal human instincts. They are the basis, or, to use a technical phrase, they form the root complex of every neurosis.

The future prospects of psychoanalysis depend upon improvement in its technique, the general cultural advance of psychoanalytic investigation, careful study of data on the effectiveness of the

method as used by different workers in the field, and finally on the rapidity with which physicians become familiar with the theory and practice of psychoanalysis as a therapeutic agent. Psychoanalysis will aid in the prevention of neuroses by throwing light on the real mechanisms which produce nervous breakdowns. The psychoanalytic method of investigating unconscious mental processes is full of promise for treating nervous invalidism due, not to overwork, but to repressed emotions and unsatisfied instincts. The analysis interprets man's unconscious motives and desires. It ransacks the personality. It has shown that the manifold symptoms of the neuroses result from unfulfilled desires which often extend back to the earliest years of life. In fact, it is of the utmost importance to recognize abnormal behavior and character traits in the very young in order to correct conditions responsible for abnormal tendencies and prevent misery and suffering in adult life.

POSTOPERATIVE APNEUMATOIS (ATELECTASIS) AND POST- OPERATIVE PNEUMONIA

Pol N. Coryllos, New York (*Journal A. M. A.*, July 13, 1929), concludes from his experiments that the determining cause of postoperative atelectasis is bronchial obstruction by viscid bronchial exudate. Postoperative immobilization of the thoracic cavity by pain, impairment of cough and respiratory movement by narcotics, and posture are only favoring factors. The dominant factor in the postoperative lung condition is bronchial obstruction and impairment of the free bronchial drainage. The fate of the lung parenchyma after bronchial obstruction depends on the microbes infecting the obstructing mucus. A nonvirulent type IV pneumococcus will produce atelectasis, a more virulent pneumonia, pyogenic and anaerobic organisms, lung suppuration or gangrene. In atelectasis pneumococcus group IV is always present, just as in pneumonia. Between them there is a difference only in the degree of virulence. Clinical evolution, roentgenographic study, pathologic changes, and, above all, experimental investigation, offer evidence for this conception.

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Meets the third Thursday in each month

G. SENERCHIA	<i>President</i>	Washington
W. H. DYER	<i>Secretary</i>	Warwick

NEWPORT

Meets the second Thursday in each month

D. P. A. JACOBY	<i>President</i>	Newport
ALEXANDER C. SANFORD	<i>Secretary</i>	Newport

R. I. Ophthalmological and Otological Society—2d Thursday—October, December, February, April and Annual at call of President.
Dr. J. E. Raia, President; Dr. F. W. Dimmitt, Secretary-Treasurer.

The R. I. Medico-Legal Society—Last Thursday—January, April, June and October. Henry M. Boss, Jr., President; Dr. Jacob S. Kelley, Secretary-Treasurer.

1930

THE SEASON'S GREETINGS

and

BEST WISHES FOR THE COMING YEAR

EDITOR

1930

EDITORIALS

EUTHANASIA.

It is a long time since this subject has been written or talked about. It features in a recently much sold book which has had its screen presentation and is at present very much in evidence because of the acquittal, by a jury, of a self confessed murder, illustrating the fact that there is still a tendency towards sympathy with this inexcusable assumption of the suitability and reasonableness of the doctrine.

In the first place it must be understood that there are very few if any cases in which pain cannot be controlled by physicians, and in the second place we have never seen a case in which provision was not made for rendering painless the last days of those suffering from incurable disease. With these facts in mind it is hard to see why there is any need of the laity taking into its hands what properly belongs to the Medical profession (i. e. care of the sick.) In this, as in many other things those not versed in medicine assume too much and perform what seem duties without the least knowledge of or training for them. As to the execution of a sick person, for it is no less, there are no words to adequately describe the atrocity of the crime. It is not done by the medical profession and it is a libel on the profession to relate such a happening in a novel. Fortunately in the cinema presentation it was not stressed or its horrific details dwelt upon, but in the book it was plain enough and cannot be other than an argument for the ignorant and imprincipled to do murder. Although we are fortunately a long way from the philosophy of Schopenhauer there is evidently need of popular teaching and the casting of a mountainous obstruction in the way of those who would urge heathenish and unwarrantable license in the propagation of a malevolent and unspeakable doctrine.

THE COMMITTEE ON THE COST OF MEDICAL CARE

In 1928 the Committee on the Cost of Medical Care instituted a five-year program of study. The membership of the committee consists of a group

of widely recognized physicians who are in active private practice, a group of public health officials who are engaged in city, federal, university and Red Cross work, a group representing institutions and organizations, such as hospitals, medical schools, charitable homes and the American Medical Association, a group of economists from the legal profession, the research foundations and purely social surveys, and, lastly, a group of men who are identified with banking, large industrial enterprises, organized labor and public welfare.

Through a well planned study over a period of five years an attempt will be made to determine as clearly as possible the present status of medical economics. Too often attempts at a sweeping reform are made without an adequate knowledge of existing conditions, with the result that new conditions fail to show an improvement over the old, or that new problems, which are most undesirable and difficult to handle, arise from ill considered changes. If there are changes needed in our present day system of the care of the sick, the ideas of a few, often fanatical in their intensity, should not be allowed to dominate the actions of many. It is therefore a pleasure to see a group representing such widely diversified interests, making a deliberate study of a very complex situation. It has been said that the best results come from study, when there is no one at hand to exclaim, *Cui bono!* Let us hope that the work of this committee may go forward unhampered and unhurried.

That the work of the committee is of timely interest and much needed there can be little doubt. In almost any gathering of physicians one hears discussions concerning the compensation of doctors, the use and abuse of various forms of clinics and of late much talk about for, or at least lower fees from, the family of moderate means. That the public is interested is evidenced by a series of articles, no less than fifty in number, published during the last two years in the best of our monthly periodicals, on the cost of sickness. From the financial point of view the criticism of the medical profession is often rather unfavorable.

The time is not so very remote when a doctor needed no greater investment than was represented by a silk hat and some pill boxes in his saddle bag. In fact, the fashions of the day did not even require the purchase of a safety razor, although he may have owned one or two lances. In contrast with that day compare the elaborate, expensive and

intricate apparatus required at the present time to administer up-to-date care of the sick. And yet, of approximately one hundred thousand physicians doing private practice in the United States, nearly all have their individual offices, with their overhead expenses, credit systems and all as different as the personalities of their proprietors. Such duplication of effort, if it existed in the production of such commodities as food, transportation, light, clothing, etc., would make the products of little value or prohibitive in price.

It should be a great source of satisfaction to the medical profession, and the public as well, to know that a carefully planned study is well under way.

FOOD

Food has always been a matter of interest in the causation and treatment of disease. Sartorius gave the study of diet its first impetus and since then a great deal of work has been done. It is surprising, however, the medical profession does not have a better understanding of the role of food components.

The researches of Lusk, Benedict, Chittenden, DuBois and others have done much toward solving the chemistry of foods in the body and toward making it clear for the physician. Others have shown the necessity of vitamins. The patient gets his knowledge of diet not from the doctor but from advertisements of commercial people interested in selling a particular brand of food. If the average physician took the trouble to inform himself on the subject of diet, extravagant advertising of food would be a far less profitable business.

CASE REPORTS

REPORT OF A CASE OF UNDULANT FEVER

MALFORD W. THEWLIS, M.D.
WAKEFIELD, R. I.

An Italian woman, aged 39, has been complaining for several months of lassitude and headaches. On November 11th she was taken ill with a fever

of 102° F. At that time she complained of chills, and headache in the left temporal region. For five days the fever continued at 103° F., and then dropped to 100° F., for one day, only to return to 104° F. Each afternoon at three or four o'clock she had a definite chill and the only other symptom she complained was headache—always in the left temporal region. Repeated smears for malaria were negative. Blood culture at the end of 72 hours was negative. Fever continued and eight typhoid and undulant fever agglutination tests were performed at various intervals, and all were negative. White cell count was 5800 with a normal differential count.

She continued to have a fever of 102° F., for three weeks, with the morning temperature abating to normal. In the third week she showed a definite tenderness over the gall bladder but it did not continue. She did not appear very ill, was not jaundiced, and in the fourth week she was able to go outdoors. The illness has caused practically no loss of weight and with the exception of weakness she seems as well as usual, although she still has an evening rise of temperature to 100° F.

As she has been dressing squirrels for sometime, tularemia was suspected but the blood was entirely negative for this disease. At the time of testing the serum for tularemia, it was found that the serum gave a positive agglutination of *Br. abortus* in dilution of 1:1280. This was verified by the Hygienic Laboratory at Washington, D. C.

Blood examinations for *Br. abortus* made from drop smears on cardboard, as for the Widal reaction, are not to be depended upon. It is necessary to examine the serum and at least 3 to 5 cc. of blood should be taken in a Wassermann tube.

Treatment of this case has been symptomatic. It will be noted that the patient has run a course similar to typhoid.

SOCIETIES

THE RHODE ISLAND MEDICAL SOCIETY

The regular meeting of the Council was called to order at 4:30 P. M., Nov. 21, 1929, at the Medical Library, the President, Dr. Frank T. Fulton, in the Chair.

The Council voted to reinstate the following men to membership in the Rhode Island Medical Society:

Dr. Simon Albert
Dr. Max B. Gomberg
Dr. Malford W. Thewlis

The Treasurer, Dr. Jesse E. Mowry, presented the following budget for the year 1930:

BUDGET, 1930

Collation and Annual Dinner	\$700.00
Expenses of Secretary (sec. hire)	75.00
Printing and Postage	125.00
Fuel	600.00
Gas	50.00
Electricity	85.00
Telephone	110.00
City Water	10.00
House Supplies and Expenses	450.00
House Repairs	500.00
Janitor	600.00
Books and Journals (including Ely Fund, \$74)	100.00
R. I. Medical Journal	400.00
Safe Deposit	6.00
Treasurer's Bond	25.00
Delegates, New England Medical Council	150.00
Librarian	1,660.00
Delegate to American Medical Association	100.00

\$5,746.00

INCOME FOR 1930

Annual Dues	\$4,300.00
Interest from Harris Fund	290.00
Interest from Ely Fund	74.00
Interest from Frank L. Day Fund	135.00
Interest from Herbert Terry Fund	100.00
Providence Medical Association	450.00
Use of Building	125.00
From Journal	400.00

\$5,874.00

Balance in Bank Nov. 1, 1929..... \$1,257.21

HARRIS FUND

Southern Illinois Light & Power Co.	\$120.00
Pacific Gas & Elec. Co.	60.00
Mort. Security Corp. of America	110.00

\$290.00

J. W. C. ELY FUND

Southern California Edison Co.	\$50.00
Mechanics National Bank	24.00

\$74.00

FRANK L. DAY FUND

Canadian National Railway	\$135.00
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HERBERT TERRY FUND

Missouri Public Service Co.	\$100.00
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The Council voted to approve the Budget as rendered and to refer it to the House of Delegates with the recommendation to adopt it.

The Treasurer also announced that he had received \$500.00 under the Will of the late Dr. James R. Morgan. The sum of money was given to the Society without restrictions, and the Treasurer expressed the opinion that this money should be segregated in a fund to be known as the James R. Morgan Fund, and the proceeds from the Fund be devoted to the current expenses of the Medical Library Building. Motion by Dr. Chase, seconded by Dr. Leech, the Council voted to approve the Treasurer's action in this regard.

The Treasurer also called attention of the members of the Council to the bad state of repair of the linoleum floor covering in the reading room. He stated that it will be necessary to replace this before long but that the state of the Society's finances does not permit this expense which would amount to about \$500.00 to be undertaken at this time.

The Secretary presented a request from Dr. Joseph F. Hawkins for an opinion as to the attitude of the Society in regard to physicians having their specialty in the practice of medicine listed in the telephone directories. On motion of Dr. Partridge, seconded by Dr. Mowry, it was voted to lay the matter on the table.

Adjourned,

Respectfully submitted,

DR. J. W. LEECH,

Secretary.

The meeting of the House of Delegates was called to order at 5 P. M., Thursday, Nov. 21, 1929, by the President, Dr. Frank T. Fulton.

The report of the Council was presented by the Secretary.

On motion of Dr. Skelton, seconded by Dr. Manchester the Treasurer's Budget as approved by the Council was adopted by the House of Delegates.

It was moved by Dr. Mowry and seconded by Dr. Skelton that the annual dues for the current year be fixed at \$10.00. So voted.

The meeting was then adjourned but reassembled at the call of the President in order to receive the report of the Library Committee with reference to the use of the books in the Davenport Library. Dr. Donley, Chairman of the Library Committee, reported that the committee was in favor of letting these books be taken out

of the Library by members of the Society with the exception of rare and first editions, and upon the following conditions:

1. Books may be borrowed by members for a period of 2 weeks and renewable for 2 weeks unless the librarian receives a request from other members for the volume.

2. No books to be kept out of the library for more than one month.

3. That a fine of four cents per day be imposed if a book is kept out beyond the four weeks' period.

A spirited discussion followed the Chairman's report. Dr. Peter P. Chase opposed the letting out of any of the books of the Davenport Library. He felt that the unique character of this Library placed these volumes in a condition comparable to museum pieces of furniture in well known collection, and he feared that the loaning of any of the volumes would result in a certain percentage of loss. The opinion that the Davenport Library will be of little use to the members unless the volumes may be taken out of the library was expressed by Doctors Gormly, Donley and Corvese. Dr. Barnes suggested that a deposit on each book taken out of the library be made by the member borrowing the book. Dr. Corvese suggested that the Committee make a list of the volumes which on account of their rarity or value could not be removed from the library and allow under certain restrictions the borrowing of the remaining volumes. Dr. Corvese suggested that if a borrower kept a volume over the one month period that no other volume shall be loaned to any member until that delinquent member returns the volume he has borrowed. On motion of Dr. Corvese, seconded by Dr. Gormly, it was voted that the matter of the Davenport Library be referred back to the Library Committee for the formulation of more definite rules which will safeguard the integrity of the Davenport Library, and that the Library Committee report at the next meeting of the House of Delegates.

Adjourned.

Respectfully submitted,

J. W. LEECH, M.D.

Secretary.

The quarterly meeting of the Rhode Island Medical Society was held December 5, 1929, at the

Medical Library, Providence. The meeting was called to order at 4 o'clock by the President, Dr. Frank T. Fulton.

The minutes of the September meeting, and of the Council and of the House of Delegates were read by the Secretary and approved.

The President announced the following deaths since the last annual meeting, and referred the matter to the Committee on Necrology for the usual action at the annual meeting.

Dr. Charles A. Glancy, Providence, R. I., died June 27, 1929.

Dr. James B. Erskine, Tilton, N. H. (non-resident member), died July 22, 1929.

Dr. John B. McKenna, East Providence, R. I., died July 27, 1929.

Dr. Oswald R. Seigel, Bristol, R. I., died July 30, 1929.

Dr. Frederick A. Vinton, Providence, R. I., died August 3, 1929.

Dr. Frederick C. Shattuck, Boston, Mass. (honorary member), died January 11, 1929.

The President made the following appointments. Delegates to the New England Medical Societies: Maine—Dr. R. C. Robinson, Dr. C. D. Sawyer. New Hampshire—Dr. W. P. Davis, Dr. R. M. Lord.

Vermont—Dr. H. E. Harris, Dr. E. S. Wing.

Massachusetts—Dr. A. R. Newsam, Dr. W. Pickles.

Connecticut—Dr. H. F. Crandall, Dr. J. E. Ruess.

Dr. Leech presented a clipping from the *Rhode Island American*, a newspaper published July 2, 1824, reporting the annual meeting of the Rhode Island Medical Society for that year. As part of the minutes of that meeting was the announcement of the formation of the Fiske Fund, a donation from Dr. Caleb Fiske on his resignation from the Society at that meeting. It was voted to accept this clipping suitably framed and to hang it on the walls of the Medical Library.

The following program was presented:

1. "Acute Cerebral Injuries," Dr. Lucius C. Kingman, Providence, R. I. Discussion by Drs. Henry J. Hoyer, George W. Van Benschoten, and C. A. McDonald.

2. "Modern Problems in the Treatment of Diabetes," Dr. Reginald Fitz, Boston, Mass. This paper was illustrated by stereopticon slides, and was discussed by Drs. Burgess, Streker and Gray.

3. "Teaching Clinics in Vienna," Dr. Harry C. Messinger, Providence, R. I.

After adjournment, a collation was served.

Respectfully submitted,

J. W. LEECH, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

The Regular monthly meeting of the Providence Medical Association was called to order by President Dr. Arthur H. Ruggles, Monday evening, December 2, 1929 at 8:50 o'clock. The records of the last meeting were read and approved. A letter from the Gorgas Memorial Institute was read. The secretary was instructed to write them that we could not contribute this year.

A letter from the secretary of the R. I. Medical Society regarding the improvement of the acoustics of the hall was read. They did not feel they could take action now. No action was taken.

The Standing Committee having approved their applications the following were elected to membership:

Albert Simon	Emery Pelletier
James P. Clune	Richard L. Shea
Preston D. Geiger	Edgar F. Stone
Frank A. Merlino	Oscar Unger
John F. Murphy	Lloyd Wilson
Frances D. O'Connell	

The list of nominations for officers and committees for the ensuing year as made by the Standing Committee was received and accepted as below:

Nomination of Officers

In accordance with Article 1, Section 6, of the By-Laws, the Standing Committee makes the following nominations for officers and committees for the year 1930.

For President—Clinton S. Westcott, M.D.

For Vice-President—John E. Donley, M.D.

For Secretary—Peter Pineo Chase, M.D.

For Treasurer—Charles F. Deacon, M.D.

For Member of the Standing Committee for five years—Arthur H. Ruggles, M.D.

For Trustee of the Rhode Island Medical Library for one year—George W. Van Benschoten, M.D.

For Reading Room Committee—George S.

Mathews, M.D., Elihu Wing, M.D., Guy W. Wells, M.D.

For Delegates to the House of Delegates of the Rhode Island Medical Society:

C. W. Skelton, M.D.	C. F. Gormly, M.D.
R. S. Wilcox, M. D.	H. McCusker, M.D.
J. W. Sweeney, M. D.	A. A. Barrows, M.D.
P. Appleton, M. D.	J. T. Monahan, M.D.
W. Pickles, M.D.	A. W. Mahoney, M.D.
G. H. Crooker, M.D.	F. W. Dimmitt, M. D.
W. S. Streker, M.D.	P. P. Chase, M.D.
E. M. Porter, M.D.	H. Libby, M.D.

J. A. Gilbert, M.D.

The first paper of the evening was read by Dr. Arthur P. Noyes on A Case of Myasthenia Gravis with Certain Unusual Features. This disease occurs more frequently in women from 20 to 50.

Symptoms:

1. Fatigue of muscles and other systems.
2. Ocular disturbances.
3. Deglutition disturbance.
4. Disturbance of facial expression.
5. Disturbance of phonation.
6. Palsies of other parts of body.

A true atrophy does not occur except from disuse. There are also visceral disturbances as of the heart and respiration and constipation. Its course is slow but progressive by exacerbations. Nervous injuries cannot be demonstrated anatomically. The myasthenic reaction to electrical stimulation is supposed to be pathonomonic. An endocrine disturbance has been thought to underlie this condition but has not been well established. Apparently this disease is of toxic origin, source unknown.

A male patient was presented.

The paper was discussed by Drs. Sanborn, Van Benschoten, Ujhely and Noyes.

The second paper on Streptococcus Hemolyticus Pneumonia was read by Dr. Ezra A. Sharp. This dealt with Broncho-Pneumonia. These were cases studied at the New Haven Hospital. They were a clinical entity. The organism was found in the sputum. A definite part of the disease was the development of an empyema which ultimately had to have surgical drainage. Tuberculosis was a frequent complication.

The paper was discussed by Drs. Gray, Richardson, Westcott, Rounds, Davis, Wing, Kramer Kelley and Sharp.

The meeting adjourned at 11:10 P. M. Collation was served. Attendance 60.

Respectfully submitted,

PETER PINEO CHASE, M.D.,

Secretary.

ANNOUNCEMENT

AMERICAN PUBLIC HEALTH ASSOCIATION

The 59th annual meeting of the American Public Health Association will be held in Fort Worth, Texas, during the week of October 27, 1930, with the Hotel Texas as headquarters.

The annual meetings of this oldest and strongest of public health organizations brings together for a week of scientific discussion, all of the public health leaders of the continent. It is always the most important health convention of the year. Health officers, nurses, dietitians, sanitary engineers, child and industrial hygienists—all of the specialists that make up the public health profession—meet to consider their common problems. Each of the ten sections of the Association—Health Officers, Laboratory, Vital Statistics, Public Health Engineering, Public Health Nursing, Public Health Education, Food, Drugs and Nutrition, Industrial Hygiene, Child Hygiene and Epidemiology—arrange an individual program and there are a number of general sessions to which the public is invited.

Detailed programs of the Fort Worth meetings will be announced in the official publication of the Association, *The American Journal of Public Health and the Nation's Health*. Further information may be obtained from the Executive Secretary, Mr. Homer N. Calver, 370 Seventh Avenue, New York, N. Y.

HOSPITALS

MEETING OF THE MEMORIAL HOSPITAL STAFF HELD OCTOBER 3, 1929

Meeting called to order by President Wheaton at 9:15 P. M.

Minutes of the April and May meetings read and approved.

Report of the Clambake Committee given by Dr. Robert T. Henry.

Report accepted with thanks and balance turned over to Dr. J. L. Turner, Treasurer of the Staff.

Dr. Earl F. Kelly of the Children's Medical Department read a very interesting paper on "Pyloric Stenosis."

He presented four cases of Pyloric Stenosis and these were discussed by Drs. A. T. Jones, R. C. Bates and C. H. Holt.

Dr. J. E. Keefe gave a very interesting portrayal of his operation on his first case of Pyloric Stenosis.

Drs. J. W. Keefe and J. A. McCann were present as guests.

Meeting adjourned at 10:20 P. M.

23 Members present.

ROBERT T. HENRY, M.D.,

Secretary pro tem.

UNDULANT (MALTA) FEVER

A method of concentration by agglutination with specific serum was applied by Harold L. Amoss and Mary A. Poston, Baltimore, (*Journal A. M. A.*, July 20, 1929), to isolate *Brucella* from the stools and parallel cultures by this method and by the usual planting on eosinmethylene blue (methylthionine chloride-U. S. P.) plates resulted in the recovery of the organisms from twenty daily consecutive specimens of stools by the former method and completely negative results by the latter. From the stools of a male patient with a history of onset of undulant fever sixteen months ago, a strain corresponding to *Brucella abortus* (porcine) has been isolated. These organisms are apparently identical with those obtained from the blood culture early in the course of his illness. It is suggested that, in cases from which the organism has not been recovered from the urine or the blood but in which the patient's serum agglutinates members of the *Brucella* group, either the patient's serum or the corresponding polyvalent or monovalent serum be used. On account of the dilution employed, the small amount of preservative may be disregarded.